events (VTE) in immobilized acutely ill general medical inpatients from the hospital perspective in Germany. **METHODS:** The incremental cost-effectiveness ratios "additional cost for ENOX per clinical VTE averted versus NPP" and "additional cost for ENOX per episode of severe bleeding (ESB) averted versus UFH" were quantified using a modelling approach based on decision-tree technique. Resource use during thromboprophylaxis, diagnosis, and treatment was collected from a hospital survey. Costs were exclusively those to hospitals and were determined by multiplying utilised resource items by the price or tariff of each item. Clinical effectiveness was taken from the MEDENOX [Samama et al. NEJM 1999] and Thromboembolism-Prevention in Cardiac or Respiratory Disease With Enoxaparin [Kleber et al. Am Heart J 2003] trials and from a meta-analysis [Mismetti et al. Thromb Haemost 2000]. The evaluation encompassed 8 (6–14) days of thromboprophylaxis plus time to treat VTE and ESB in hospital. **RESULTS:** The base-case analysis revealed incremental cost of €1543 for ENOX per clinical VTE averted versus NPP, whereas ENOX dominated UFH. In comprehensive sensitivity analyses, using impact analysis and Monte Carlo simulation, the robustness of the model was shown. In no case had the price of ENOX the main impact on cost effectiveness. In 95% of 10,000 simulation steps, incremental cost for ENOX ranged between €201 and 4 €154 per clinical VTE averted versus NPP. In 91% of 10,000 simulation steps, ENOX remained dominant over UFH. **CONCLUSIONS:** In acutely ill general medical inpatients, ENOX offers hospitals in Germany a highly cost-effective thromboprophylaxis compared to NPP and an enormous saving potential when used instead of UFH.

PCV40

ASSESSMENT OF THE COST OF CARDIOVASCULAR DEATH

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OBJECTIVES: Cardiovascular death is an important endpoint in clinical trials. In health-economic analyses it also plays a key role in the calculation of the number of life years gained. Unlike other outcomes like myocardial infarction (MI) or stroke, not much research has been done on the assessment of specific resource use in patients dying of a cardiovascular cause. This study assessed the cost of cardiovascular death in Belgium. **METHODS:** In this cost-of-illness study, data on resource utilisation were retrospectively collected in patients with a history of MI who died in the hospital in the year 2002. Four hospitals were selected based on setting (community-university) and geographical region (north and south). Direct medical costs from the health care payer's perspective, as expressed by the intensity of medical resource consumption in physical units, times the direct cost or charge per unit, were considered. Costs were defined as cost of hospitalisation (basic care and nursing), drug use, diagnostic tests, physician consults and technical interventions. **RESULTS:** The charts of 60 patients were reviewed (mean age: 76 ± 11 years). The average length of stay was 5.28 days (St. Err. 0.64). The main causes of death were MI (37%), cardiogenic shock (22%) and ventricular fibrillation (20%). The average hospitalisation cost €2045 (St. Err. €215), the drug cost €383 (St. Err. €97), the cost of diagnostic tests €344 (St. Err. €42), the cost of physician consults €29 (St. Err. €7) and the cost of technical interventions €943 (St. Err. €207), resulting in a total cost of death from cardiovascular disease of €3744 (St. Err. €431). In the Northern part the average cost is about €1000 higher compared to the Southern part (€4284 vs. €3239) (NS). **CONCLUSIONS:** Cardiovascular death is not only an important clinical endpoint but also an important economic parameter due to its high cost.

PCV41

A COST ANALYSIS IN PATIENTS WITH ACUTE CORONARY SYNDROMES USING CLOPIDOGREL IN ADDITION TO ASPIRIN IN A HONG KONG PUBLIC HOSPITAL

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OBJECTIVE: Results from the Clopidogrel in Unstable Angina to Prevent Recurrent Events (CURE) study showed that clopidogrel plus aspirin, comparing to aspirin alone, reduced the cardiovascular events (death, myocardial infarction, and stroke) in patients with acute coronary syndromes (ACS). Yet the acquisition cost of clopidogrel is much higher. It would therefore be worthwhile to compare the long term cost impact of these 2 regimens. **METHODS:** Until recently, only very few patients with ACS received a clopidogrel-aspirin combination therapy in Hong Kong. Therefore a hypothetical cohort was formed and compared to a real group of patients treated with aspirin alone. For the aspirin group, medical history was reviewed and cardiovascular and gastrointestinal events occurring in a period of 12 months after initiation of therapy were recorded. The target cost items included hospitalisation, emergency room visits, outpatient clinic visits, related medications, diagnostic tests, procedures and surgery. For the hypothetical cohort, the probabilities/relative risks for clinical events were adopted from the CURE study. The unit cost of drugs and other resource items were based on the Hong Kong Hospital Authority drug acquisition cost 2001 and Hong Kong Government Gazette 2003 respectively. The perspective of the study was that of a public health organisation. **RESULTS:** Fifty-four consecutive patients with ACS receiving aspirin therapy were identified over the period of January 1, 2001 to December 31, 2001 from a major public hospital in Hong Kong and studied.